STATEMENT ON TRICARE IN DOD REGIONS 3 AND 4

SUBMITTED BY:

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PRESENTED TO:
HOUSE ARMED SERVICES COMMITTEE
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STATEMENT OF

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INTRODUCTION

Mr. Chairman and members of the Committee, thank you for the opportunity to speak to you today regarding the Department of Defense (DoD) TRICARE Program. I am Dave Baker, President and CEO of Humana Military Healthcare Services, Inc. (HMHS). HMHS is a wholly owned subsidiary of Humana Inc., one of the nation's largest publicly traded managed health care companies. HMHS was formed in 1993 to concentrate on DoD opportunities like TRICARE, by assembling a group of key managers who understand health plan operations and the delivery of care to military beneficiaries. We are the DoD contractor for managed care support Regions 3 and 4, which encompasses the southeastern United States. Included in these regions are Alabama, Florida, Georgia, the eastern third of Louisiana, Mississippi, South Carolina, and Tennessee. Approximately 1.1 million DoD beneficiaries are eligible to receive health care benefits under this contract which began delivery of health care on July 1, 1996. HMHS has subcontracted with Blue Cross/Blue Shield of South Carolina, d/b/a Palmetto Government Benefit Administrators (PGBA), to process TRICARE claims.

My statement today will cover:

- Successes:
  - Operational,
  - Partnering,
  - Appointment setting, and
  - E-Commerce initiatives.
- Concerns:
  - TRICARE 3.0,
  - Pharmacy, and
  - Custodial care.

OPERATIONS

HMHS is pleased that the year 2000 has been declared the "Year of Health Care." The care available to military beneficiaries has come a long way in a short time. Of course, there is always room for improvement.

The quality and administration of the TRICARE program is a personal issue for me because the military health system is my health system. As the son of a career military officer, Military Treatment Facility (MTF) providers delivered the health services I received as a child. During my own 27 year active duty Air Force career, I not only used the military health system, but also served as a health care administrator. I can tell you first-hand, that the TRICARE program provides coverage options, health care services and customer services never before available under TRICARE's predecessor, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). I am pleased to report that HMHS' administration of the TRICARE contract has refined and improved along with the TRICARE program itself.

As evidence of this attestation, enrollment in TRICARE Prime in Regions 3 and 4 exceeds 500,000 – nearly half of the 1.1 million eligible beneficiaries. HMHS is especially encouraged by the fact that nearly every person who enrolls in TRICARE Prime, elects to continue his or her enrollment each year. Including beneficiaries who relocate or lose eligibility, our reenrollment rate is approximately 90 percent. Of these enrollees, 74 percent are assigned to MTF Primary Care Managers (PCMs), while the remaining 25 percent have civilian PCMs. Our Prime enrollment has reached these heights due, in part, to the fact that more than 95 percent of all eligible beneficiaries have a Prime provider network available in their area. In addition to the care available at the MTFs, HMHS has contracted with approximately 29,300 providers – including 6,000 PCMs -- 4,700 pharmacies and 580 hospitals. To demonstrate the success of our network development efforts, the DoD established a standard that there

should be one PCM for every 2,000 Prime enrollees and one provider of any type for each 1,200 enrollees. HMHS maintains a network that includes one PCM for every 85 enrollees and one provider for every 17 enrollees. This robust network helps ensure that virtually everyone, who wants to, can take advantage of the TRICARE Prime or Extra options.

One of the many advantages of the TRICARE Prime program is that network providers file claims on behalf of their patients. As you are aware, claims filing can be a cumbersome process. HMHS strives to make claims submission as painless as possible and has made great strides in the simplification of the filing process. To accomplish this, more than 150 government directed changes have been made to the claims system and more than 100 additional enhancements have been initiated by HMHS and our claims processing partner. These enhancements and streamlined procedures, enabled PGBA to process more than 8.3 million claims during 1999. Even more impressive is the fact that approximately 87 percent were processed in 21 days or less. This far exceeds the government standard, at that time, which stated that 75 percent of claims should be processed in 21 days.

Proliferation of electronic claim filing was one of the strategies we used to exceed government benchmarks. In 1999, approximately 47 percent of claims were submitted via electronic means. There are several advantages to both providers and beneficiaries when electronic filing is used. Providers are able to identify claims with missing or discrepant information almost immediately. As a result, there is no need to wait for manual intervention by a claims processor. PGBA experience shows that electronic claims pay faster than non-electronic claims. For instance, during the last six months of 1999, on average, electronic claims completed processing more than ten days faster than paper claims. HMHS would welcome all claims electronically, however, some providers do not have the appropriate technology.

The DoD recently adopted new claims processing standards. We are now required to process 95 percent of retained claims within 30 days. Since the implementation of these standards, our performance has steadily increased and, during February of this year,

approximately 96 percent of retained claims were processed within the 30 day benchmark. These statistics demonstrate the advances made to date, but there are more to come.

PARTNERING

Close partnerships between contractors and military officials are a vital element of TRICARE that facilitates resolution of unforeseen problems or differing expectations. To this end, HMHS has developed exceptional working relationships with all our military customers including TRICARE Management Activity (TMA), the Regional Military Lead Agent staffs, and the MTF staffs. Coupled with good relationships with our providers and the beneficiaries we all serve, we believe that, in the overwhelming majority of circumstances, we are meeting or exceeding beneficiary needs and expectations.

HMHS continues to work on global policy issues with TMA, which serve to enhance the TRICARE healthcare benefit. By partnering with TMA, the Lead Agents, and MTFs, HMHS has been able to positively impact and successfully implement TRICARE program changes, including TRICARE simplification, TRICARE Prime Remote and the new Supplemental Health Care Program.

During the course of the DoD TRICARE Region 3 and 4 contract, we have been awarded several honors that highlight these partnerships. As a testament to this, HMHS and the Lead Agent and MTFs in Region 3 won the 1999 National Managed Health Care Congress (NMHCC) Partnership Award – a first for a TRICARE contractor. This prestigious honor, sponsored by the Astra Pharmaceuticals Corporation, recognized our partnership efforts, which have improved quality and enhanced access, and reduced Government healthcare costs.

APPOINTMENT SETTING

Another example of our successful partnering efforts can be found in our appointment setting function. Within the scope of the Region 3/4 contract, HMHS has a limited role in scheduling beneficiary appointments. In fact, HMHS was originally contracted to provide this service primarily for the Keesler Medical Center at Keesler Air Force Base in Biloxi, Mississippi. We were later requested to extend services to cover the Branch Medical Clinic Pascagoula, the Naval Ambulatory Care Clinic in New Orleans and for an Air Force family practitioner located at the Branch Navy Clinic in Gulfport, Mississippi. The center averages over 24,000 incoming calls per month. In addition, HMHS is involved in setting appointments for four PCMs (approximately 1,200 appointments per month) at Millington, Tennessee.

Although this function is not required throughout our contract, HMHS is dedicated to providing superior service to those TRICARE beneficiaries who use it. Since 1996, the DoD Health Affairs Patient Satisfaction Surveys have rated the Keesler Appointment Services higher than all other military health system military treatment facility averages and higher than civilian HMO averages for appointment services.

At the recent annual Worldwide TRICARE Conference in Washington, DC, Brigadier General Dan Locker, Keesler Medical Center Commander, was presented with TMA's annual MTF Access Award from Dr. Sue Bailey, Assistant Secretary of Defense for Health Affairs. The award recognizes the medical center for meeting all DoD criteria for beneficiary access to care, including ease in making appointments and timely treatment by care providers. Brig. Gen. Locker acknowledged HMHS' significant contribution to Keesler in winning this prestigious award. HMHS is proud of the service we provide to all our TRICARE customers and continuously pursue additional ways to improve this service.

E-COMMERCE INITIATIVES

One of the most exciting advancements made by HMHS this year was the introduction of e-commerce capabilities. On November 18, 1999, HMHS announced the unveiling of a new e-business tool that offers TRICARE network providers and hospitals up-to-the-minute, online access to information about their patients, coverage, authorizations, referrals, claims, and practice patterns. These options are available to all medical TRICARE network providers throughout Florida, Georgia, Alabama, Tennessee, Mississippi, and the eastern third of Louisiana.

This online enhancement gives network providers the power to verify the eligibility and enrollment status of TRICARE beneficiaries. If providers are not sure whether a procedure is a covered benefit or if prior authorization is required, they can reference detailed information on-line regarding American Medical Association Current Procedural Terminology (CPT) codes. When prior approvals are required, providers have the ability to submit an online request virtually 24 hours a day, seven days a week (excluding periodic "downtime"). In addition, providers can monitor the progress of their requests and enter additional comments if they so choose. As providers track their requests, they can review the rationale behind the determinations in the context of the nationally accepted guidelines used in the evaluation process. Further, they can follow their patients' treatment online with a feature that gives primary care managers confidential access to comments entered by specialists.

Additional enhancements are on the horizon. On a monthly basis, our providers can review their practice patterns and compare the frequency and/or cost to the patterns of their peers. These comparative reports are available to our providers at home, in the office, or while traveling. These reports include information regarding inpatient, outpatient, emergency and pharmacy services. Primary care physicians can produce listings of the TRICARE patients assigned to their practice. Color graphics and reports give an overview of the services

provided. These tools provide a baseline that enables doctors to evaluate the quality and efficiency of treatments used for their patients and compare it to the treatment patterns of their peers over a 12-month period. The graphics provide a quick indication of those services that are in and outside the norms. The data that is used to comprise each month's overview is accessible at the click of a finger or through a search function. Physicians can use this information to ensure their patients are receiving the most appropriate level of care. For instance, providers are able to see which of their patients required a visit to the emergency room and verify that the proper follow-up care has been received.

Although all the practice profiles are available on-line, providers may also download the data to their computers in various software programs for more in-depth analysis. To ensure that personal information about TRICARE beneficiaries is not released inappropriately, access to this data is secured by an encrypted user name and password login procedure. Additionally, practitioners are only able to access information regarding the patients they are treating.

In addition to the tools provided for the clinical side of the practice, assistance will also be available for the business side. Each day, providers will be able to track the processing of their TRICARE claims. If a claim has been deferred for any reason, each line item can be viewed to help pinpoint the reason for the deferral, thus allowing faster response time when follow-up is required.

These enhancements have been made despite the fact that fixed price contracts, such as the TRICARE contracts, do not consistently reward these types of contractor initiated innovations. Nevertheless, we believe that as providers are empowered with information on their practice patterns, efficiencies will occur and quality can improve.

Despite all of the advances made to the TRICARE program, some concerns and challenges remain which we have begun to address with the DoD.

TRICARE 3.0

The DoD has begun implementation of TRICARE 3.0, which is an initiative to overhaul the contracting and administrative aspects of the TRICARE program. HMHS is assessing the features of TRICARE 3.0 but has concerns that some performance requirements may be unrealistic and could escalate the cost of providing managed care services to DoD beneficiaries.

We are working with our DoD customers to identify those areas which we believe could yield substantial benefits at significantly less cost. We believe this communication between the DoD and the contractors is essential to developing initiatives that will provide continuous improvements. Cooperative efforts that combine the knowledge of the military and commercial health care systems can bring about plans and programs that are uniform and feasible. In Regions 3 and 4, HMHS has been successful in forming such partnerships, which have resulted in efficient and coordinated administration of the TRICARE program.

PHARMACY

As you are no doubt aware, increases in drug price and utilization have caused prescription medications to become an ever-larger proportion of total health expenditures. In 1980, prescription drugs accounted for 5.5 percent of personal health care costs. By 1990 the percentage had increased to 6.1 percent and by 2008, experts predict that drug expenditures will be 12.6 percent of total personal health care expenditures.[1] In order to meet the challenge of escalating pharmacy costs and help improve quality of care, the DoD, at the urging of Congress, has begun a redesign of the TRICARE pharmacy benefit.

[1] Health Insurance Association of America, Prescription Drugs: Cost and Coverage Trends, September 1999

One of the most promising aspects of the pharmacy redesign is the creation of an integrated data system warehouse. Currently, TRICARE beneficiaries can fill their prescriptions through three military benefit programs: the Military Treatment Facilities (MTFs); TRICARE contractor network pharmacies; and the National Mail Order Pharmacy (NMOP). In each case, patient prescriptions are screened for drug allergies, interactions and duplicates -- but only against the patient profiles in the dispensing pharmacy's database. This procedure allows for clinical screening to occur on only a subset of the patient's total drug profile, as the patient may have varying and incomplete profiles on file with all three programs. With the integrated database being developed by DoD, each program will be able to conduct prospective drug utilization reviews on a common patient profile containing complete information from all three programs. HMHS eagerly awaits the implementation of this aspect of pharmacy redesign. We are convinced it will reduce patient exposure to medication risks and achieve cost savings for beneficiaries, the Government and contractors.

One of the most common concerns discussed by TRICARE beneficiaries is the disparity of pharmacy benefits across the country. The current DoD pharmacy program does not provide for uniformity. In most cases different drugs are available at MTF pharmacies, contractor retail pharmacies and the NMOP. The DoD pharmacy redesign includes an integrated formulary with uniform limitations, exclusions and prior authorization requirements. HMHS believes this coordinated and uniform strategy is ideal. Beneficiaries will be ensured of access to the same medications at all DoD outlets. Prior authorizations based on uniform standards could be utilized by all systems. Implementation of the DoD pharmacy redesign is a giant step in removing barriers for beneficiary access to health care.

Complementary to DoD's changes, HMHS is also making internal adjustments to remove barriers. Our pharmacy Help Desk is available daily to assist physicians and pharmacies with the prescription process. Pharmacies that electronically submit prescriptions through our Pharmacy Benefits Manager (PBM) can obtain immediate answers to their claims submission questions. The Help Desk also assists physicians' navigation of the prior authorization process. Once HMHS receives a completed prior authorization request from a physician,

a decision is generally made on the request in one business day. HMHS has also initiated a demonstration project to allow non-network pharmacies to electronically submit the claims through our PBM. This project has exciting possibilities for the removal of barriers for TRICARE beneficiaries and providers.

CUSTODIAL CARE

Another issue of growing concern to Congress and to TRICARE beneficiaries is the definition of custodial care under the Department of Defense TRICARE program. Although changes have been proposed, current TRICARE Policy (Chapter 8, Section 6.1), defines custodial care as:

> Care rendered to a patient (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living and (4) who is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an RN, LPN, or LVN.

Relying on this DoD definition, under the existing TRICARE program, benefits are not available for services related to a custodial care need, except for prescription drugs, medical supplies and durable medical equipment, and one hour of skilled nursing care per day.

Also, current TRICARE policy recognizes that occasional physician monitoring may be required to maintain the patient's condition, including up to twelve physician visits per calendar year (not to exceed one per month).

Increasingly, we are witnessing beneficiary discontent concerning this limited benefit. In response, the DoD has implemented the Individual Case Management Program (ICMP) in accordance with provisions of the 1993 National Defense Authorization Act. The ICMP allows DoD (Health Affairs) to authorize exception to this limitation allowing coverage of care for TRICARE beneficiaries with extraordinary medical or psychological disorders. These beneficiaries may receive DoD coverage for medical or psychological services, supplies, or durable medical equipment that are currently excluded by TRICARE regulation.

All medically necessary health care can be authorized for a patient under ICMP, regardless of the medical status of the beneficiary. For custodial care cases only, the DoD ICMP will pay for: (1) services that require the supervision of trained medical, nursing, paramedical, or other specially trained individuals; and (2) are not designed to assist an individual in meeting the activities of daily living.

The ICMP program is working for beneficiaries in TRICARE Regions 3 and 4 when HMHS and the DoD work together to coordinate the appropriate coverage of care for the patient. As an example, HMHS recently became aware of a 4-month-old child who has required assistance for all activities of daily living since birth. The family relocated from Texas to Georgia on December 15, 1999. Our case manager contacted the family before the transfer and counseled them regarding ICMP benefits. HMHS worked with the family to proactively initiate the application and with expeditious resolution by the DoD, the child was approved for seven hours per day of skilled nursing care effective December 13, 1999. This enhanced coverage began before the child even reached our region.

Application for the ICMP program, as it interfaces with the TRICARE contractors, has been an evolving process and progress is being made. Nevertheless, too often the program has been difficult to administer and confusing to beneficiaries. Unfortunately, HMHS has also

been confused by contradictory instructions and rapidly changing guidance regarding the application and approval process. In one case, for example, DoD directed us to send a determination letter authorizing 8 hours of skilled nursing. The next day (subsequent to mailing the initial letter) we were directed to hand deliver a different letter providing the family with skilled nursing care 24 hours a day, seven days a week for 60 days.

Notwithstanding the problem, HMHS will continue to work with DoD to standardize and improve the ICMP process. We look forward to definitive, written guidance.

As Congress and the DoD move forward with custodial and respite care coverage decisions, it should be noted that this care is extremely expensive. HMHS has estimated that the average ICMP case will cost approximately $110,000 per annum. In addition to the five cases that have already been submitted to DoD for consideration, we are currently aware of seven potential cases in DoD TRICARE Regions 3 and 4 alone.

As previously mentioned, custodial care has never been a covered benefit under the basic TRICARE program. If a patient has been determined to be custodial and the only care they receive is custodial, then they often discontinue partial or complete use of their TRICARE benefit. Should coverage of custodial care be fully implemented, the DoD should be prepared to fund services for beneficiaries who had left, or never used, the system who are likely to return to seek coverage for their condition. Many custodial care cost estimates, including our own, have not accounted for these non-reliants who will wish to use expanded TRICARE custodial care benefits.

We continue to work with the DoD on the implementation and administration of the ICMP program in TRICARE Region 3 and 4. We look forward to formalizing the procedural interface with the DoD to extend the extraordinary ICMP benefit to needy beneficiaries.

CONCLUSION

Although there is always room for improvement, TRICARE is working. Incredible strides in the delivery of quality military health care have been made since the days of CHAMPUS. The DoD has done a commendable job in their continuous efforts to enhance the system, always with the welfare of the military beneficiaries foremost in mind. HMHS looks forward to continued collaboration with the DoD to advance the TRICARE program.